TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
TX HEALTH DBA INJURY 1-DALLAS

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-16-2098

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT codes 97545WHCA and 97546WHCA were preauthorized…therefore it is deemed medically necessary."

Amount in Dispute: $4,896.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical treatment at issue consists of work hardening with dates of service March 23, 2015 through April 16, 2015. For multiple reasons, this request should be denied. The claimant's injury s limited to aright knee strain. Furthermore, the claimant reached maximum medical improvement within two months of the date of injury. The impairment rating assigned for the compensable injury was 0%. There is insufficient evidence the treatment at issue was related to the compensable injury."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 23, 2015 through April 16, 2015	Work Hardening Program CPT Codes 97545-WH-CA and 97546-WH-CA	$4,896.00	$1,536.00

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- P12-Workers' compensation jurisdiction fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 285-Please refer to the note above for a detailed explanation of the reduction. Full denial PLN-11 and DDE in file only compensable body part is a sprain/strain to the knee.
- 219 – Based on extent on injury.
- 216-Based on the findings of a review organization.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Extent of Injury? Are the disputed services eligible for review by Medical Fee Dispute Resolution?
2. Is the requestor entitled to reimbursement for services rendered on April 3, 8, and 10, 2015?

Findings

1. Based upon the submitted explanation of benefits, the respondent denied reimbursement for services rendered on March 23, 24, 26, 30, April 15 and 16, 2015 based upon reason code "219 – Based on extent on injury." In addition, the respondent denied reimbursement for date of service April 13, 2015 based upon reason code "285."

   Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   The division finds that due to the unresolved extent of injury issues for the above listed dates, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.307 and §141.1.

   Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

2. The requestor billed the respondent for a work hardening program rendered on April 3, 8, and 10, 2015 that was denied payment based upon reason code "P12."

   28 Texas Administrative Code §134.204(h)(3)(A) and (B) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97545WH and 97546WH for 24 hours on April 3, 8, and 10, 2015. Therefore, per 28 Texas Administrative Code §134.204(h)(3)(A) and (B), the MAR for a CARF accredited program is $64.00 per hour. $64.00 times the 24 hours billed is $1,536.00. The respondent paid $0.00. The difference between the MAR and amount paid is $1,536.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,536.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,536.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/21/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.